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ABSTRACT

Guidelines for implementing a plan to integrate an HIV positive child into the educational mainstream are offered in this paper. Although the issue involves a special health problem, the action plan is applicable to any controversial integration project. Components of the plan include working with parents and students, curriculum development, training staff and parents, and media relations. Other important factors include honesty, cooperation, acceptance, and respect of family/child privacy. (LMI)

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SUCCESSFUL INTEGRATION

AN ACTION PLAN

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August, 1987, Glendale Elementary School District received a call from the Arizona Department of Health. The conversation was relatively short. The salient points were as follows -- "You may have a child who may live in your district who may attend the public schools and may be HIV positive. Do you have an AIDS policy?" We did not at that time have an AIDS education policy in effect. We were; however, fortunate in as much as, the Superintendent had served on a statewide committee the previous spring. One of his tasks was to develop an AIDS policy for use by local school districts. Additionally, he had had informal conversations with the school board concerning the importance of such a policy. Little did he know at the time that this would become a very important preliminary step to what would follow in the fall of 1987. Immediately, the Superintendent convened a working committee of administrators to develop an itinerary of what was to become a very successful integration of an HIV positive child into the public schools. The committee consisted of the Superintendent, the Assistant Superintendent for Curriculum, Director of Staff and Program Development, District Head Psychologist, and the local unit Principal. During the next few weeks, the committee would meet a number of times with the parent of the affected child, the Department of Health officials, and the district's legal counsel. After much fact gathering, it was determined that the child posed no health danger to other children. Quite the contrary, other children posed more danger to the affected child. Further, the legal issues were very clear. Ryan White had already fought and successfully won what all

children should be entitled to, that is the right of a Free Appropriate Public Education, some months before in Indiana.

The issues and directions the district should take were very clear. All that was left was to convince 8000 district children and their parents that they had nothing to worry about. Four years later, the child is still attending public school successfully and anonymously. The community takes a great deal of pride in this because they did what was right. Within the city limits of Glendale, Arizona, there is a young child and a family who are very thankful for the Rays of Florida, the Whites of Indiana, and the citizens of Glendale, Arizona.

The following components we found to be very important in implementing a successful integration plan for an HIV positive child into the regular education mainstream. Although the plan was developed for use with the HIV positive child, it holds merit for any controversial integration.

--Working with Parents

--Development of a K-12 Comprehensive Health Program

--Training (Teachers, Classified Employees, Office Staff and Parents.)

--Working with the Press

--Working with the Children

In our particular case, the planning for the above areas was done at the same time because of the time restraints. However, under normal conditions, you would develop your own priorities as they best fit your particular case.

--Working with Parents

Dealing with parents and their apprehensions is one of the keys to the success or failure of the integration process. The facts are on your side regarding safety of children. However, general fear and misunderstanding clouds facts. When you involve their children, it is difficult for them many times to accept logic and factual information regardless of how credible the information may be.

You do NOT want to get into an adversarial relationship with the parents of the affected child, or for that matter, any of the parents. Remember, for many parents, this is a very emotional issue, so you must be patient, calm, and very factual to help reassure them.

After initial meetings to inform parents, break into smaller groups. In our case, I met with the parents of each classroom separately, one per night. We had a doctor, school psychologist, and curriculum person at each meeting. This allowed our meetings to be informal as well as informative. With the panel, we were able to answer ALL questions. The small group allowed us to isolate and deal with parent concerns. It is very important to deal in factual manner and to reassure parents that their child is not in any danger. Most parents do not have the facts, many have half truths and rumors. Also,

we met every night. When we had gone through each classroom, we began the process again and continued until there were no parents showing up for the meetings. Slowly, the apprehension level began to decrease and the trust level increased.

—Curriculum Development

We began our efforts in developing an AIDS Education Curriculum by involving our teachers, administrators, and parents on our committees. In 1987, there was not much quality in predeveloped curriculum packages. This allowed us to custom fit our program to our curriculum, but it was hard to find quality factual material for inclusion into our curriculum. Today, the Arizona Department of Education Comprehensive Health Unit, under the direction of Karleen McNichols has developed curriculum guides and packages for training and implementing programs.

From a broader sense your AIDS education program should be part of a K-12 comprehensive health curriculum. This should have been in place long before an AIDS crisis. However, for a lot of reasons, many districts do not have one in place.

The question always comes up what should be included in such a curriculum. Below, I have listed one example. The areas are a recommendation of the Association for Supervision and Curriculum Development. It comes from its Contents of the Curriculum 1988 Yearbook. Chapter nine is written by Richard G. Schlaadt, Professor and Head, Department of School and Community Health, College of Human Development and Performance, University of Oregon, Eugene. The

curriculum can be divided into the following nine areas.

1. Accident Prevention and Safety
2. Community Health
3. Consumer Health
4. Environmental Health
5. Family Life Health
6. Mental and Emotional Health
7. Nutrition
8. Personal Health
9. Disease Prevention and Control
10. Substance use and abuse

As pointed out earlier, it is important to have not only professional staff involved in the curriculum development, but also parents. The successful acceptance by the community is important for the implementation of any program. In addition to Karleen McNichols, you will also find Anita Cohen from the National Parent Teachers Association a valuable resource. The PTA has worked very close with the Center for Disease Control helping develop AIDS education and comprehensive health programs.

--Training

Training of your certified, classified staff, as well as, parents is an integral part of your program. It is not only necessary information, but serves as a part of your curriculum package. In Glendale, we trained every person who worked at the school in any capacity.

It is important to point out that during training sessions, we focused on generally good health habits, not on just the AIDS virus. Because no one knew the identity of the affected child, except the homeroom teacher, this helped draw attention away from AIDS and more to generally good hygiene.

The district purchased and began using disposable rubber gloves for use anytime we came into contact with bodily fluids of any kind. In reality, we should all be doing this regardless of whether there is an AIDS child, or not. We also had our teachers begin focusing on good health habits of children and discussing them in class regularly as part of the instructional week.

All employees, from district administrators and teachers to bus drivers and parent volunteers were trained. After the initial training, similar inservices were set up to handle new employees or parents who had missed the initial sessions. Again, the training became an important part of our instructional program. It gave us an opportunity to teach people good health practices, but in the process we were able to get across important AIDS and communicable disease information in a non-offensive manner. The training was a very inexpensive way of building parent support and developing a rather large group of supportive parents and employees.

--Working with the Press

I really believe that a large part of our success was because of our ability to work with the press, especially during the first 72 hours. Notice, I said working WITH the press. It is very impor-

tant that the press is supportive.

In Glendale, to some extent, we were fortunate because there had been a great deal of negative press coming out of Florida and Indiana with the Rays and the Whites. I believe the press wanted a positive story as much as we did.

We must realize that the members of the press are professionals who are trying to report the news. If you try to suppress information without telling them the reason or you are not honest, you meet the press with an adversarial relationship where you and the children lose.

During the early stages, when the story was news, we set up a regular time when the press could speak to either myself or the superintendent. It is imperative that whoever speaks with the press, that the story is accurate and the same. As the weeks passed and community acceptance grew, the contacts became fewer and less regular. However, whenever the press wanted to speak to us, we made ourselves available. Equally as important, whether talking to a group of parents, or the press or the television, the message was always consistent.

Although we were extremely cooperative with the media, one thing we would not allow was the media into the schools to interview or photograph students. This caused some concern on the part of the media initially. However, because our reasons were stated, and we were consistent with all media representatives, they accepted the

regulation. Our feeling was that our main objective was the education of ALL of the children who attended our schools, to have members of the media in and out of the school and classrooms would disturb this process. This also allowed our teachers to have "quality time" regarding the AIDS issue without media fanfare. This proved to be very important.

—Working with the Children

In the beginning stages, during the first month or two, students had many questions. The event was getting a great deal of news coverage; children would see it on television and read about it in the paper. Additionally, many of their parents were attending the parent classes and training. We asked our teachers to be sensitive to their concerns and answer their questions. We wanted to make sure that it was talked about openly as appropriate and that the information given was correct. If they did not know, we asked them to tell the children that, but to make sure that they got back to them with the correct answer. The teachers were calm and factual during their presentations. We were aware that the children would model the behavior of their teachers. All questions by parents were handled the same way. Because of the opportunities for parent input, we received few phone calls and had only ONE parent withdraw their child. I believe this can be attributed to the calm, factual and professional manner all employees handled questions. Within 4 to 6 weeks, it was no longer an issue and we could continue to plan and implement our curriculum.

In retrospect, the fact that we were open and honest with all parties included helped turn what could have been a very negative situation, as it was in other parts of the country, into a very positive community building process. Also, the fact that we were able not to enter into adversarial relationships with either the family, parents, or the press was very important. This did not happen automatically. It was something we were conscious of and worked on consistently. We did everything possible to be open but keep a very low key approach.

The fact that we opted to keep the family name and the child's identity private is very important. Having an HIV positive family member is enough to deal with. They do not need an onslaught of publicity even if it is positive.

We become so blase as parents about the good things that happen to us. Christmas and family time is so important, but we have the feeling that there will always be another Christmas. School pictures, such a little thing, are important. We want to keep a pictorial history of our children, but we know there will always be a chance to get pictures taken. However, the family with the HIV positive child never knows when this will be the last Christmas they have to share or the last opportunity for a school picture. For these and many other reasons the family needs support, and a lot of time to share privately as a family for their time is limited.

If we are not open and aggressive in accepting these families, they will continue to carry a secret while attending school, and a burden that many times they had no part in selecting. We, as educators, will have missed an opportunity to do what we do best - educate.